UNITED STATES OF AMERICA

NATIONAL LABOR RELATIONS BOARD

UNITY CENTER FOR BEHAVIORAL HEALTH, Employer, and OREGON NURSES ASSOCIATION, Petitioner.	Case No. 19-RC-241339

EMPLOYER'S REQUEST FOR REVIEW OF THE REGIONAL DIRECTOR'S DECISION AND DIRECTION OF ELECTION

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I. PRELIMINARY STATEMENT

Pursuant to 29 C.F.R. § 102.67 of the Rules and Regulations of the National Labor Relations Board ("Board"), Legacy Emanuel Hospital and Health Center ("LEHHC") requests review of the Regional Director's Decision and Direction of Election, dated June 12, 2019 (the "Decision"), which found that "[a]ll full-time and regular part-time nurses employed by the Employer at Unity Center for Behavioral Health" constituted an appropriate unit for collective bargaining.[1] (Decision at 11.) Review is requested pursuant to 102.67(d)(1)(ii) on the basis that the Regional Director's Decision departed from Board precedent by (1) refusing to apply and ignoring the Board's Health Care Rule for acute care hospitals, and (2) wrongly finding one unit/department of LEHHC to be a separate facility. Review is also requested pursuant to 102.67(d)(2) on the ground that the Decision on substantial factual issues is clearly erroneous and such errors prejudicially affect LEHHC's rights. Review is additionally requested pursuant to 102.67(d)(1)(ii) because this case raises substantial questions of law and policy, including whether it was appropriate for the Regional Director to apply the single-facility presumption to direct an election in a unit at odds with the Health Care Rule and the Congressional admonition against undue unit proliferation in acute care hospitals.[2]

II. SUMMARY OF ARGUMENT

LEHHC operates a single acute care hospital whose patient care units are located in three different buildings: Legacy Emanuel Medical Center ("Emanuel"), Randall Children's Hospital at Legacy Emanuel ("Randall"), and Unity Center for Behavioral Health ("Unity"). Each of these

[1] The Regional Director's Decision and Director of Election is attached hereto as Exhibit A. The hearing transcript and exhibits are annexed hereto as Exhibit B. References to the hearing transcripts are cited as "Tr. ___." Exhibits are cited as "EX ___"; "UX ___." References to the Decision are cited as "Decision at ___."

[2] Alternatively, review is requested pursuant to Section 102.67(d)(4) to the extent that the single facility presumption applies at all in the instance of a single, unified, acute care hospital that merely has physically distinct acute care units.

buildings contains different acute care units/departments that make up the single LEHHC acute care hospital. These buildings are not separate facilities – they are all part of a single acute care hospital. Because they are not separate facilities, the so-called "single facility presumption" had no place in this proceeding. Rather, under the Health Care Rule, the only appropriate unit for this single acute care hospital is all LEHHC registered nurses.[3] The Regional Director violated the Health Care Rule by directing an election among only the LEHHC registered nurses who work at Unity.

Alternatively, while Unity is not a separate facility from the rest of LEHHC, even if one assumes that it is, the Regional Director erred in applying the single facility presumption to nurses who work at Unity because under the Board's single facility/multi-facility analysis, the only appropriate unit is all registered nurses who work at LEHHC.

III. STATEMENT OF FACTS

A. Background And Legacy Emanuel Hospital And Health Center

Legacy Health ("Legacy") is a multi-hospital healthcare system based in Portland, Oregon. (Tr. 17.) It includes six acute care hospitals in Oregon and Washington, including (1) LEHHC, (2) Good Samaritan Medical Center, (3) Mount Hood Hospital, (4) Meridian Park Hospital, (5) Salmon Creek Medical Center, and (6) Silverton Hospital. (Tr. 17.) In addition to providing acute care services at its hospitals, Legacy provides other outpatient medical services to patients at physicians' offices, clinics, laboratories, and other facilities at various sites in Oregon. (Tr. 17.)

LEHHC is a single, 554-bed licensed hospital, employing approximately 1,659 registered nurses hospital-wide, across various disciplines and specialties, providing primarily inpatient medical and surgical services to patients who are admitted on a short-term basis. (Tr. 18.) It is

[3] LEHHC also operates additional ambulatory care clinics, both at the Emanuel campus and in other locations. The Employer is not arguing to include nurses working at those clinics in the acute care hospital unit. References to "LEHHC" herein thus refer only to the acute care hospital that includes Emanuel, Randall and Unity.

comprised of three buildings, which include (1) Legacy Emanuel Medical Center, (2) Randall Children's Hospital at Legacy Emanuel, and (3) Unity Center for Behavioral Health. (Tr. 17, 678.)

Randall is located adjacent to Emanuel and shares the same address. Unity is located in a building one mile away, which is about a 15 to 20 minute walk. (EX 9; Tr. 78.) Unity is located in a separate building because Emanuel lacked the physical capacity to house the LEHHC expanded psychiatric operation when it opened in January 2017. (Tr. 53-55 (noting that Emanuel "had outgrown . . . the capacity that [it] had to care for behavioral health patients"); *see also* Tr. 236, 30, 35.)

Historically, LEHHC operated for decades with all acute care departments in a single building, including, as relevant here, pediatrics (now in Randall), adolescents (now in Randall), adult care (remaining in Emanuel's building), and mental health services (now in Unity). (Tr. 35, 73-74, 127, 585; *see also* Tr. 578-582.) Over the years as LEHHC has grown and expanded, it permanently moved or transferred its pediatric, adolescent, and mental health services departments out of Emanuel to larger, stand-alone buildings, all located within a short distance of its original building at Emanuel. (Tr. 18-19, 268, 271, 349, 377.) Initially, nursing services were provided to patients on different floors, first of Emanuel only, and then of Emanuel and Randall, once the Randall building opened. (Tr. 127; Tr. 579-580, 585.) Then, when Unity opened, LEHHC relocated its adult and adolescent mental health services departments from Emanuel and Randall, respectively, to Unity. (Tr. 74, 349, 377.)

Importantly, registered nurses, their supervisors, and employees providing other services such as environmental services (housekeeping) and patient access, all transferred over to the new physical location at Unity. They continued to provide mental health services to patients that had previously been provided at Emanuel and Randall and registered nurses (and other employees) continued to report to the same supervisors, albeit at a different physical location, with more

employees overall, and an enhanced service model that includes more refined psychiatric emergency services. (Tr. 268, 271, 349, 377.) However, the type of care (i.e., behavioral health) remains the same. (*See id.*)

LEHHC, inclusive of Emanuel, Randall, and Unity, functions and operates as a single acute care hospital, but each building serves the medical and surgical needs of different patients. (EXs 1, 2, 4, 5, 11-14, 16, 17, 22, 24-31, 55.) Emanuel is a Level 1 trauma center and it provides a comprehensive range of medical services primarily to adults, including advanced surgery. (Tr. 19, 35.) Randall provides medical services mostly to infants, children, and adolescents, although it will also include LEHHC's family birth center once completed, which will care for mothers during childbirth and their newborn infants. (Tr. 19, 582.) Unity provides inpatient mental (or behavioral) health services to adults and adolescents, as well as psychiatric emergency services as part of Emanuel's emergency room. (Tr. 18-19.).[4]

The average length of a patient's stay at LEHHC is fewer than 15 days. (EXs 10, 59, Tr. 59.) For instance, in 2015 and the first quarter of 2016, patients were admitted to patient care units at Emanuel and Randall with an average length of stay of far less than 30 days (an average of 5.9 days). Once established in 2017, Unity also had similar patient stay statistics. (*See* EX 59.) Between April 2018 and March 2019, patients at Unity were admitted with an average length of stay of far less than 30 days (between a monthly average of 7.4 days and 14.90 days). (EX 10; *see also* UX 33 at p. 30 of 52, Tr. 59.)

[4] Unity was formed as a partnership between a number of acute care hospitals in the Portland area. The partner hospitals participate on a managing board and share in Unity revenue (positive or negative). However, for all operations purposes, Unity operates as the Mental Health department of the single LEHHC acute care hospital. (Tr. 590, EX 55, p. 15; Tr. 590.) Thus, all terms and conditions of employment for nurses and all other LEHHC employees working at Unity are determined by LEHHC, and their supervision is exclusively through LEHHC. Employees working at Unity are LEHHC employees for *all* purposes. (Tr. 50, 53-54, *see* EX. 52.) Therefore, the formation partnership and agreement on share of revenue is immaterial to a unit determination.

Significantly, Unity has never operated as a stand-alone hospital, and Unity has never been a separate entity; rather, Unity is the Mental Health department of LEHHC that provides psychiatric services to patients at LEHHC. (*See* EXs 2, 3, 55; Tr. 588-590.) Consistent with this organizational structure, of LEHHC's 554 beds, 107 beds are located at Unity. (EXs 4, 5.) Unity's corporate registration application filed with the Oregon Secretary of State lists LEHHC as the "Registrant/Owner" of Unity. (EX 3.) Unity holds itself out to the public as part of LEHHC, including on employee business cards, other marketing materials, and patient bills; they all refer to "Legacy Emanuel." (*See, e.g.*, Tr. 528, EXs 40, 41, 60.) Patients at Unity who require surgery are, except in rare instances, always transferred to Emanuel. (Tr. 138, 546.) Unity's Psychiatric Emergency Services or "PES" is part of Emanuel's Emergency Department (i.e., the psychiatric emergency portion of the Emanuel ED). (Tr. 51-52, 481.) Unity's "Scope of Services for Psychiatric Emergency Services" reflects that Unity, Randall, and Emanuel have established protocols for transferring patients within the LEHHC acute care hospital, depending on the care required:

> **Criteria for Transfer**
>
> a. In general, patients with complex medical/surgical care needs are precluded from admission to the PES.
>
> b. ***Adult patients presenting with a medical condition requiring evaluation and treatment beyond the scope of UCBH [i.e., Unity] services will be transported to the Legacy Emanuel Emergency Department for evaluation and treatment.***
>
> c. ***Pediatric patients presenting with a medical condition requiring evaluation and treatment beyond the scope of UCBH services will be transported to Randall Children's Hospital Emergency Department at Legacy Emanuel for evaluation and treatment.***

(UX 10 at pp. 92-93; emphasis added.)

LEHHC also maintains a specific set of outpatient/operating procedures for patients admitted to Unity who require treatment for non-mental-health service ailments at Emanuel. (EX

42.) When Unity's patients are treated at Emanuel, the patients are not discharged from Unity; rather, the patients are treated as if they are receiving care from unit to unit, not from one separate facility to another: "Nurses should treat th[e] patient as a ***unit to unit transfer. Not a new admit.***"[5] (EX 42.)

Further, Emanuel, Randall, and Unity all utilize the same operating rooms. (Tr. 39.) X-rays and imaging (*i.e.*, MRIs and CT scans) are operated and managed centrally for Emanuel, Randall and Unity. (Tr. 138, 291, 496-97.) Among other interchange of employees, physical and occupational therapists, pharmacists, and chaplains travel across all three buildings visiting patients as needed. (Tr. 36-37, 57.)

B. LEHHC Is Accredited, Licensed And Surveyed As One Hospital Entity

Besides functionally and operationally being a single acute care hospital, LEHHC is also accredited as one through the Joint Commission. (Tr. 19-22, 69, 201-204; EXs 1, 2, 14, 58.) The Oregon Health Authority Public Health Division ("OHA") issues LEHHC a single, operating license that encompasses Emanuel, Randall, and Unity. (EXs 1, 2; Tr. 19-20; Tr. 27.) Unity's OHA-operating license reflects this fact, noting that Unity is the "Unity Center for Behavioral Health – ***a service of Legacy Emanuel***." (EX 2; emphasis added.)

Consistent with this single licensing arrangement, when LEHHC sought permission from the OHA to transfer five patient beds from Emanuel to Unity, it did so as an intra-hospital transfer

[5] Two of the Union's registered nurse witnesses testified that patients at Unity requiring non-psychiatric medical treatment could be transferred to other area hospitals, rather than being transferred within LEHHC. (*See, e.g.*, Tr. 396, 505.) However, this is not correct. Because Unity's psychiatric emergency department or "PES" is a part of LEHHC, the Emergency Medical Treatment And Labor Act – a federal law that governs hospital emergency departments – requires that a patient who presents at Unity's psychiatric emergency department and who needs another type of treatment be transferred within LEHHC for that treatment. (*See* Tr. 528-529.) Further, Legacy Health's Revenue Cycle Director, who oversees how patients access LEHHC and Legacy's other hospitals, testified that she did not believe that patients being seen at the Unity unit were ever transferred outside of LEHHC for non-psychiatric treatment. (Tr. 494, 496.) In addition, Union witnesses acknowledged that patient transfers from the PES "go directly to Emanuel," unless Emanuel cannot accept the patient due to capacity reasons, an infrequent occurrence. (Tr. 327, 496; *see also* Tr. 505.)

within and under OHA's license for LEHHC, not as an addition to Unity's overall patient bed count. (EXs 4, 5.) Regarding the transfer of beds from Emanuel to Unity, the OHA found:

> It has come to our attention that your facility Legacy Emanuel Medical Center will be moving five beds from the main campus to the Unity satellite location, License #14-0056-4.
>
> Because the total number of beds reflected on the hospital license will remain unchanged, a paper license will not be issued. We have noted this change to our records.

(EX 5.)

The Centers for Medicare and Medicaid Services ("CMS") defines LEHHC as a single "acute care hospital" under the Medicare Act and its authorizing regulations, including for survey evaluation purposes. (Tr. 21-22, 197-198, 201-204, 593, 596.) CMS uses the Joint Commission to survey hospitals and all LEHHC departments are subject to Joint Commission review, including Unity. (EX 58, Tr. 22.) Thus, in May 2018, when the Joint Commission and CMS found that Unity was not in compliance with certain of CMS's regulations, Unity's deficiencies jeopardized the entire LEHHC hospital's status under the Medicare Act and its authorizing Regulations. (Tr. 23-24.) Specifically, in its finding, the CMS observed in its report regarding Unity's lack of compliance:

> This report reflects the findings of the unannounced complaint investigation survey, #0R14492, initiated onsite **at the Legacy Emanuel Medical Center's off-campus satellite behavioral health inpatient and outpatient facility, the Unity Center for Behavioral Health**, on 04/26/2018.

(EX 12, at p. 1; emphasis added.) Consistent with CMS's treatment of LEHHC as a single hospital entity, LEHHC's National Provider Identifier ("NPI") and Provider Transaction Access Number ("PTAN"), which are used for Medicare billing purposes, are the same across all three entities. (EX 16.) Medicare and non-Medicare billing for Unity is through LEHHC as well. (EX 40.)

C. LEHHC's Administrative Organization And Operations

LEHHC's administration and top supervisory and managerial hierarchy are all centralized. (Tr. 88, 112, 170-174, 195, 496-97, 590.) Gretchen Nichols ("Nichols"), the Interim President of Unity, reports directly to Bronwyn Houston ("Houston"), the President of Randall and the Interim President of Emanuel.[6] (EXs 6, 7, 8; Tr. 575-576.) Kari Howard ("Howard"), the Vice President and Chief Nursing Officer at Unity, reports to Nichols. (Tr. 163, 165; EX 8.)

Prior to Nichols assuming the role of President of Unity, from December 2017 to March 2019, Trent Green ("Green"), the current Senior Vice President and Chief Operating Officer of Legacy, was the joint President of both Emanuel and Unity. (Tr. 576.) Green directly oversaw and managed Emanuel and Unity in this capacity. (Tr. 576.) In April 2019, Green assumed the role of SVP and COO of Legacy, and LEHHC installed Houston, the then-President of Randall as the Interim President of Emanuel. (Tr. 575.) Houston retained her position as Randall's President. (Tr. 575-76.) LEHHC installed Nichols as the Interim President of Unity in February 2019 before Green's departure. (Tr. 34, 99.)

Before April 2019, Emanuel and Unity had a single Chief Nursing Officer, Linda Jones ("Jones"), and Jones reported to Green, the then-joint President of both Emanuel and Unity. (Tr. 165.) LEHHC changed this reporting relationship given the size and scope of the positions at both Emanuel and Unity. (Tr. 45.) This change in reporting structure did not otherwise alter LEHHC's licensing, accreditation, or how direct care RNs interact with LEHHC management. (Tr. 110.) Further, top supervisory directors from Emanuel, Randall and Unity rotate duty as the "Administrator On-Call" for the entire LEHHC acute care hospital to make decisions on emergency problems, which may arise at all three physical locations. (Tr. 195-196.)

[6] LEHHC historically has had separate presidents for Emanuel and Randall, and intends to continue that model given the size of the hospital and the resulting scope of the positions. (Tr. 626.)

LEHHC maintains one set of Medical Staff Bylaws, "Medical Staff Bylaws of Legacy Emanuel Hospital & Health Center," which together govern and control the medical staff at Emanuel, Randall, and Unity. (EX 55, Tr. 588-590, 635-636.) The Bylaws specifically define the "Hospital" as LEHHC, and note that "Mental Health" is one of the established departments at LEHHC. (EX 55, pp. 7, 15.) Dr. Greg Miller of Unity serves as the Chair of the Mental Health Department within LEHHC. (EX 55, p. 15; Tr. 590 (**Q:** And who occupies that chair position at this point? **A:** Dr. Greg Miller from Unity serves as the chair of mental health).) Notably, the overall President of the LEHHC Medical Staff can come from Unity, Randall, or Emanuel. (Tr. 588-589.)

LEHHC-employed hospitalists perform medical rotations for patients at both Emanuel and Unity, or both Randall and Unity, depending on whether they are treating adults or children. (Tr. 47-48, 108-109.) Indeed, LEHHC's current medical staff president, Dr. Gordon Johnson, treats patients for medical conditions at Unity. (Tr. 632-633) Psychiatric services at Unity are performed by physicians who have contracted with LEHHC to provide those services. This is no different from contracted physicians who perform other specialties at LEHHC. (Tr. 46-47.) All employed and contracted physicians are governed by the LEHHC medical staff by-laws. (Tr. 88.)

As a single acute care hospital, LEHHC shares support services across Emanuel, Randall and Unity. These include spiritual care (chaplains), environmental services (housekeeping), food and nutrition (cafeterias as well as inpatient meals), patient access, pharmacy, occupational and physical therapy, certain imaging functions for patients (such as Magnetic Resonance Imaging or MRIs and computerized tomography or CT scans, which are conducted at Emanuel), security, and utilization management. (EX 23; Tr. 36-37, 138, 586; *see also* EX 8.)

Three Employee Relations Consultants in Human Resources share oversight of LEHHC as well. (Tr. 122, 125.) Employee Relations Consultant Ruth Marquis is responsible for the

employee and labor relations functions jointly at Unity and certain areas at Emanuel, including acute care therapy, patient transportation, and radiology. (EX 17; Tr. 122, 155.) Employee Relations Consultant Mary Starmont ("Starmont") is responsible for the employee and labor relations functions for certain areas jointly at Emanuel, including adult areas, and for pharmacy services across Emanuel, Randall and Unity. (Tr. 124.) Starmont is also responsible for negotiating collective bargaining agreements for the bargaining units represented by the Service Employees International Union Local 49 (a non-professional employee unit) and United Food & Commercial Workers Local 555 (pharmacists and pharmacy technicians) that already exist at LEHHC. (Tr. 126, 130.)[7] Cat Shaff is responsible for the employee and labor relations functions at Randall. (EX 17, Tr. 123.) The Employee Relations Consultants generally maintain offices at all of their respective buildings.[8]

In addition, LEHHC also shares a number of system-wide functions with Legacy. Legacy has one central Human Resources Department, which services all departments and locations of Legacy, including LEHHC. (EX 17, Tr. 122.) Nurses in the Resource Pool are hired by HR to be available to float to various Legacy hospitals, including LEHHC. (Tr. 529-531.) Over the last year period, 98 Resource Pool nurses have worked at Unity. (EX 44.) Legacy recently expanded the Resource Pool to include a Behavioral Health Resource Pool within the broader Legacy Resource Pool:

> For the Behavioral Health Resource Pool: Three years behavioral health experience. Previous medical/surgical experience strongly preferred, i.e. experience with discontinuing IVs, basic dressing changes, lab draws, etc.

[7] Starmont also has responsibility for the Legacy-wide "Resource Pool," which supplies additional nurses to LEHHC and other system hospitals on an as-needed basis, and the system-wide staffing office.

[8] Employee Relations Consultant Keith Grimm maintains an office at Good Samaritan Medical Center as that is his primary assignment. (Tr. 158-159, *see* EX 17.) However, Grimm is currently temporarily responsible for food and nutrition at Emanuel as well. (EX 17.)

(EX 43.) This is still part of the system Resource Pool; there is no Unity-specific Resource Pool. (EX 43, 45, Tr. 549.)

Legacy and HR issues one set of personnel policies applicable to all employees, including all of those at LEHHC. (Tr. 134, EX 22.) There are no Unity-specific Human Resources policies. (Tr. 150-152.) However, there are behavioral health specific policies that apply to Unity due to the particular nature of medical services provided there. (*See* Ex. 46.) That is the same as other unit- or specialty-based policies within LEHHC. For example, Emanuel's Emergency Department maintains a policy concerning how to deliver safe, high quality, and integrated health care to its patients, including for medical conditions such as chest pain and traumatic injuries. (UX 11(B), at pp. 4-5 of 7.)

Nurses apply for employment at LEHHC through a single, Legacy employment portal. (Tr. 403.) The Human Resources Department drafts the actual offers of employment. (Tr. 567.) Although nurse managers have the authority to hire registered nurses, they do so in consultation with the Human Resources Department. (Tr. 263-64.) Any nurse who is hired must satisfy the minimum qualifications of the jobs as established by Legacy and Human Resources, and the basic fundamental knowledge and skills are the same for registered nurses at Unity, Randall, and Emanuel. (Tr. 263-64.) Individual locations and departments can supplement but cannot override these policies. (*See* Tr. 536, 540-42.)

There is also a Legacy-wide patient records system at Legacy, which all nurses at LEHHC use, called named "Epic." (Tr. 304.) It is uniform across all Legacy facilities. (Tr. 304, 323-324.) Non-Legacy hospitals must use a separate program through Care Everywhere Network to access the Epic records system at LEHHC. (*See id.*)

Patients interchange among all three buildings, depending on the care needed, although for billing purposes patients sometimes are admitted and discharged between Unity and the other

buildings because of the difference between mental health care and physical health care for billing. (Tr. 138, 479-482; *see also* Tr. 235-236 (RN describing interchange between Randall and Unity).) This was the same process that was followed when the mental health departments were within the Emanuel buildings. (Tr. 478-481.) In addition, there is no discharge for Unity patients who get outpatient treatment at Emanuel. (EX 42.) When Unity patients are billed, their bills state a "Legacy Emanuel" address. (EX 40.)

D. All Registered Nurses At LEHHC Share Common Terms And Conditions Of Employment

Legacy sets uniform terms and conditions of employment for all nurses at Legacy Health, including those at LEHHC. As noted above, LEHHC employs approximately 1,659 registered nurses hospital-wide, across various disciplines and specialties. (Tr. 18.) All of the employees at Unity, including registered nurses, are employed by LEHHC. (Tr. 55.) All nurses at LEHHC share the same job descriptions and job codes. (Tr. 184-183, EXs 27-31.) All nurses enjoy the same set of fringe benefits and all call in sick to the same staffing office. (Tr. 139, 358.) Pay scales for the nurse classifications are determined by the system, and all LEHHC registered nurses receive pay according to these scales. (Tr. 192.)

Initial training of nurses and orientation attended by all new LEHHC nurses are done centrally on the main LEHHC campus, and all incoming LEHHC nurses are currently required to attend the same three-days of nursing training. (Tr. 191-192, 341, 403, 548.) Contrary to the Regional Director's suggestion, if any registered nurse will be working around potentially violent patients at any of the LEHHC acute care hospital buildings, the nurse will receive the same restraint and seclusion training that is necessary for the job. (Tr. 528; *see* Decision at 4.) After the general orientation for new nurses, additional training is also done in the department where each employee will work. (Tr. 223-25.) LEHHC also operates a program of continuing medical education courses open to all nurses at LEHHC. (Tr. 189.) These courses run at Emanuel and Unity. (Tr. 189.)

Although the particular type and method of providing care to patients from specialty to specialty may differ, nurses perform the same fundamental functions and similar work across all units within all three buildings, including patient assessments, medication management, charting, care planning, carrying out any treatments, and generally advocating for their patient. (Tr. 324, 326, 343, 378-380.) Working conditions that may be unique to the LEHHC mental health departments that are within Unity are based on differences of the patients served, and exist across the varied disciplines within any acute care hospital, whether it is in a single building or multiple buildings. (Tr. 384.) Even the Union's own witnesses acknowledged that the nursing practice at Unity varies due their specialty and that the differences in nursing practice would also be present among different specialties from unit to unit in any given hospital:

> Q: Okay. Is it your understanding that the scope of practice for an emergency room nurse would be different than the scope of practice for a nurse working in an operating room?
>
> A: Absolutely.

(Tr. 325 [Union witness Sarah Mittelman testifying].)

> Q: Under the unit – well – so does a behavioral health nurse have a different scope of practice than an ED nurse?
>
> A: I mean, I think typically for any unit you work on, you get unit-specific training to that unit. And then -- yeah, but if you're talking scope of practice under licensure, then, I mean, that's -- all nurses have that who go through nursing school and get registered as nurses.
>
> . . .
>
> Q: Okay. So a nurse working in an emergency department has different competencies than a nurse working on med surg unit --
>
> A: Yes.

(Tr. 344 [Union witness Jeff Ferrier testifying]; *see also* Tr. 432-433 (acknowledging that all nurses deal with mental health issues).)

Q: Do you agree with me that there's a scope of practice that covers all nurses?

A: I do.

Q: Okay. And then within specialty units, there's different competencies that nurses will have; do you agree with that statement?

A: Yes.

Q: Do you agree that the competencies in the ICU would be different than the competencies in a traditional emergency room?

A: Yes. For the most part.

(Tr. 344 [Union witness Julianne Christopherson testifying].)

The basic registered-nurse competencies required of every nurse working at LEHHC, including those at Unity, are identical. (*Compare* UX 10, at pp. 116, 120 [Unity] *with* UX 11, at p. 7 [Emanuel]; *see also* Tr. 324-325, 343.) Again, even the Union's witnesses acknowledged this fact:

Q: You mentioned that there are general nursing responsibilities that are applicable across all of nursing. Can you describe what those are?

A: Patient assessment, care planning, and then carrying out any treatments orders that we need to.

Q: Advocating for the patient?

A: Yeah. That's mostly in general.

Q: Right.

A: Yeah.

Q: Okay. Medication management?

A: Yes.

Q: Would that also be included across all of –

A: Yes.

Q: -- nursing? Okay.

(Tr. 343 [Union witness Jeff Ferrier testifying]; *see also* Tr. 324-325 [Union witness Sarah Mittelman testifying].) These basic competencies include demonstrating basic Standards of Performance, and fluency in the nurse's area of specialization. (*Id.*) The Standards of Care at Unity and the Standards of Care at Emanuel reveal that registered nurses in all departments within both buildings are performing the same fundamental jobs, including (1) coordinating "the interdisciplinary plan of care" and applying the nursing process in doing so; (2) completing a nursing assessment within four hours of admission; (3) assessing/reassessing major bodily functions and document those assessments; and (4) assessing and documenting fall risk on admission to the hospital. (*Compare* EX 47 *with* UX 10 at pp. 61-63.)

Further, contrary to the Regional Director's suggestions, nurses at Unity, Randall, and Emanuel all respond to medical emergencies. (UX 10, at pp. 76-77; Decision at 4-5.) The day-to-day supervision of registered nurse work assignments, discipline and similar matters is largely handled by supervision within the various nursing departments. That is consistent with the nature of the nursing profession and the various specialties within it, and is the same whether the various nursing departments are in the same building or not. (Tr. 256, 258-59.)

Nurses at LEHHC are all eligible to receive a certification bonus when they obtain a recognized certification approved for the nurse's specialty area. (Tr. 543-44.) The approved certifications for each specialty area are determined by the Chief Nursing Officer. Linda Jones, the CNO of Emanuel, in consultation with Kari Edwards, determined which certifications would be approved for the nurses working at Unity. (Tr. 542-545.) They receive the bonus for a behavioral health certification, but also are eligible to receive it for certifications related to Medical-Surgical and Emergency Services due to the applicability of the certification to their specific department. (Tr. 542-43; EX 50.) Nurses working in medical-surgical and emergency

services departments within Emanuel or Randall also are eligible for these same certifications. In December 2018, 16 nurses at Unity received these certification bonuses, including Union witness Sarah Mittelman, who received a $1,569.00 bonus on December 8, 2018 for receiving the Certified Emergency Nurse certification. (Tr. 545, EXs 49, 50.)

All inpatient units and the Emergency Department at LEHHC, including all nurses working at Unity, are staffed and scheduled by a centralized staffing office. (Tr. 260-61.) LEHHC maintains a centralized and LEHHC-wide "Hospital Nurse Staffing Committee." (Tr. 170-171.) Oregon law requires this. (Tr. 171, 173.) The purpose of the Hospital Nurse Staffing Committee is explained in its Charter as follows:

> To provide a forum for Legacy Emanuel Medical Center patient care departments, which includes Legacy Emanuel Medical Center, Randall Children's Hospital, and Unity Center for Behavioral Health, to develop, implement and evaluate department-based nurse staffing plans to ensure that the hospital is adequately staffed to meet the healthcare needs of the patients.

(EX 26.) Nurses from all units at Emanuel, Randall, and Unity, make up the LEHHC Hospital Nurse Staffing Committee and serve on the committee together, reflecting that LEHHC is a single acute care hospital:

- EMC – Adult Day Surgery Unit [*i.e.*, Emanuel, Tr. 37]
- EMC – Cardiac Catheterization Lab
- EMC – Cardiovascular Intensive Care Unit
- EMC – Emergency Department
- EMC - Endoscopy
- EMC – Interventional Cardiac and Vascular Recovery
- EMC – Medical Acute Care Unit (Unit 15)
- EMC – NeuroTrauma Intensive Care Unit
- EMC – Oregon Burn Unit
- EMC – Surgical Services
- EMC – Post Anesthesia Care Unit
- EMC – Progressive Cardiac Care Unit (Unit 53 and 54)
- EMC – Trauma Recovery and Acute Care Unit
- EMC – Surgical Orthopedics (Unit 43)
- EMC – Surgical Specialties (Unit 45)

- EMC – Medical Specialties (Unit 55)
- RCH – Mother Baby [*i.e.*, Randall, Tr. 37]
- RCH – 4th floor
- RCH – 6th floor
- RCH – 8th floor
- RCH – Childrens Day Treatment Unit
- RCH – Children Day Surgery / Procedure Suites
- RCH – Childrens Emergency Department
- RCH – Neonatal Intensive Care Unit
- RCH – Pediatric Intensive Care Unit
- Unity – 1E
- Unity – 1W
- Unity – PES [i.e., Psychiatric Emergency Services]
- Unity – Unit 2
- Unity – Unit 5
- Unity – Unit 6

(EX 26; *see also* Tr. 170-171.) The Hospital Nurse Staffing Committee develops, monitors, evaluates and modifies the nurse-staffing plans for LEHHC, inclusive of Emanuel, Unity, and Randall, to ensure that all units are appropriately staffed with registered nurses:

> Pursuant to Oregon Revised Statutes (ORS) and Oregon Administrative Rules (OARs), including the requirement for a hospital to develop and implement a written hospital wide staffing plan, the ORS also requires the development of a hospital nurse staffing committee (HNSC) that develops, monitors, evaluates and modifies the staffing plan as needed.
>
> - To ensure the intent of ORS and OARs are upheld
> - To provide effective staffing practices/policies that meet the healthcare needs of our patients
> - To ensure consistent application of staffing practices/policies across all hospital-based units/departments
> - To provide a forum to approve staffing plans
> - To provide a forum for staff to express feedback and concerns regarding staffing

(EX 26.) Kari Howard, CNO of Unity, served as the management co-chair of the LEHHC Hospital Nurse Staffing Committee from January or February 2016 to September 2018. (Tr. 170.) Further, the OHA, which oversees the compliance with this law, specifically required LEHHC to have a

single nurse staffing committee for purposes of instead of subcommittees since they are all one single hospital entity. (EX 24; Tr. 173-174, 178.)

The Hospital Nurse Staffing Committee, in setting the staffing plan for each of the enumerated nursing departments of LEHHC, determines the minimum nurse staffing required, based on patient census and acuity. (Oregon Administrative Rules ("OAR"), Chapter 333, Division 510-0110(2).) This staffing plan is mandated by the Oregon Nurse Staffing Law. (OAR, Chapter 333, Division 510-0110(1).)

Further, under Oregon law, if the hospital and direct care nurse representatives of the staffing committee are unable to come to agreement on staffing plans, there is a dispute resolution procedure that results in mediation. (OAR, Chapter 333, Division 510-0120.) Also under the Oregon Nurse Staffing Law, there are provisions for selecting the direct care nurse representatives on the staffing committee. (*Id.* at 510-0105(4).) If a union represents the direct care nurses working at the hospital, the union is empowered to select the direct care nurses on the Hospital Nurse Staffing Committee. (*Id.* at 510-0105(4)(c)-(f).)

The Regional Director's conclusion that the Hospital Nurse Staffing Committee does not exercise real authority in determining required nurse staffing is preposterous, not supported by the evidence, and directly contrary to the requirements of the Oregon Nurse Staffing Law, which expressly contains detailed provisions on what the staffing plan developed and maintained by the Hospital Nurse Staffing Committee must include:

> **333-510-0110**
> **Nurse Staffing Plan Requirements**
>
> (2) The staffing plan:
>
> (a) Must be based on the specialized qualifications and competencies of the nursing staff and provide for the skill mix and level of competency necessary to ensure that the hospital is staffed to meet the health care needs of patients;

> (b) Must be based on a measurement of hospital unit activity that quantifies the rate of admissions, discharges and transfers for each hospital unit and the time required for a direct care registered nurse belonging to a hospital unit to complete admissions, discharges and transfers for that hospital unit;
>
> (c) Must be based on total diagnoses for each hospital unit and the nursing staff required to manage that set of diagnoses;
>
> (d) Must be consistent with nationally recognized evidence-based standards and guidelines established by professional nursing specialty organizations such as, but not limited to: The American Association of Critical Care Nurses, American Operating Room Nurses (AORN), or American Society of Peri-Anesthesia Nurses (ASPAN);
>
> (e) Must recognize differences in patient acuity and nursing care intensity;
>
> (f) Must establish minimum numbers of nursing staff, including licensed practical nurses and certified nursing assistants, required on specified shifts, provided that no fewer than one registered nurse and one other nursing staff member is on duty in a unit when a patient is present;
>
> (g) Must include a formal process for evaluating and initiating limitations on admission or diversion of patients to another hospital when, in the judgment of a direct care registered nurse or a nurse manager, there is an inability to meet patient care needs or a risk of harm to patients; . . .

(*Id.* at 510-0110(2)(a)-(g)).

There is interchange of employees, including nurses, among all three buildings. (Tr. 192-196, 212, EX 32.) For patient care reasons, nurses can only float to departments and specialties where they are sufficiently trained to perform the work. (Tr. 212.) Thus, nurses tend to float within their particular nursing specialty. Over a one-year period, 30 registered nurses interchanged between Randall or Emanuel, and Unity, working between one to 19 shifts. (EX 32.) In addition, as noted above, nurses in the Legacy Resource Pool float among LEHHC, including Emanuel, Randall, and Unity. (EX 43, Tr. 529-531.) Over a one-year period, over 90 registered nurses floated from the Legacy Resource Pool to perform work at Unity. (EX 44.)

Support employees in environmental services, food and nutrition, patient access, physical therapy aids, patient transport associates, patient dining assistants, language interpreters,

storekeepers, among others, float among Emanuel, Randall and Unity, and bid on their particular work assignments in accordance with their collective bargaining agreement with LEHHC. (EX 19, at pp. 4-5, 34-36.) And as noted above, hospitalists, pharmacists, pharmacy technicians, physical therapists, and the spiritual care director interchange throughout LEHHC as well. (Tr. 47, 49, 57, 124, 133, 143, 196-197). For instance, some pharmacists works two days at Unity and then one day at Emanuel, pursuant to their collective bargaining agreement with LEHHC. (Tr. 143; EX 20.)

The paychecks issued to Unity's employees, including its nurses, contain LEHHC's business identification number or "BIN." (UX 15; *see also* EX 51, which reveals that LEHHC is a single entity for federal tax purposes.) Lastly, when nurses and all other employees of LEHHC are separated and seek to collect unemployment insurance, those benefits are all drawn from a single-LEHHC employer account, regardless of whether the employee worked at Emanuel, Randall, or Unity. (Tr. 560, 564, EXs 51, 52.)

E. LEHHC Has Pre-Established Bargaining Units Inconsistent With The One Certified By The Regional Director

The existing Service Employees International Union Local 49 ("SEIU") and United Food & Commercial Workers Local 555 ("UFCW") bargaining units at LEHHC all cover bargaining unit employees working at Emanuel, Randall, and Unity. (Tr. 126-127, 130-132, 522, 528, EXs 18, 20, 21.)

The SEIU's collective bargaining agreement is between "Legacy Emanuel Hospital & Health Center" and "Service Employees International Union Local 49." (EX 148.) The term of the agreement is July 1, 2017 through June 30, 2020. (*Id.*). In the SEIU collective bargaining agreement, the locations listed as "Hospital" in the preamble include Emanuel, Randall, and Unity, and they are all defined as a single hospital for purposes of collective bargaining:

> THIS AGREEMENT is made and entered into on November 6, 2017 by and between LEGACY EMANUEL MEDICAL CENTER, RANDALL CHILDREN'S HOSPITAL AT LEGACY EMANUEL and the UNITY CENTER FOR BEHAVIORAL HEALTH of Portland, Oregon, hereinafter called "Hospital," and "SERVICE EMPLOYEES INTERNATIONAL UNION, LOCAL NO. 49, of Portland, Oregon, hereinafter called "Union."

(EX 18, p. 1; Tr. 126-128.)

The UFCW's collective bargaining agreements are between "Legacy Emanuel Hospital & Health Center" and "United Food & Commercial Workers Union Local 555." (EX 20, 21.) They cover pharmacists or pharmacy technicians working at Emanuel, Randall and Unity. (Tr. 132.)

These bargaining units are NLRB-certified units and have existed for many years. (*See id.*) When Unity opened, employees included in each of these bargaining units were transferred to Unity and continued to be covered under the existing collective bargaining agreements. (Tr. 128-129, 522-23.) In addition, the SEIU petitioned to add the new classification of "Behavioral Health Assistants" working in Unity's Psychiatric Emergency Services to their hospital-wide bargaining unit, and LEHHC did not contest the appropriateness of doing so. (Tr. 128-130; EX 19.

IV. THE PETITION AND THE HEARING

A representation hearing was held on May 21, 22, and 23, 2019 to determine whether the Union's petitioned-for unit consisting of all registered nurses at Unity was appropriate. LEHHC contended at the hearing, as it does herein, that Unity cannot be considered a stand-alone single facility; but rather, the appropriate "single facility" must be the acute care hospital that Unity is a part of – LEHHC. Moreover, LEHHC further contended that because LEHHC is an acute-care single facility, the Board's Health Care Rule for acute-care facilities ("Health Care Rule" or "Rule") must apply, and the only appropriate unit is a unit of all registered nurses at LEHHC's

acute care hospital. LEHHC also argued, alternatively, that if the Regional Director incorrectly views Unity as a separate facility, the Board's single facility presumption has been overcome.

The Union contended that Unity alone should be considered a single facility; that Unity is not an acute care facility under the Health Care Rule; and that LEHHC has failed to rebut the Board's single-facility presumption.

V. ARGUMENT

A. The Board's Health Care Rule Applies Because LEHHC, Inclusive Of Emanuel, Randall, And Unity, Is An Acute Care Hospital Under The Rule

By finding Unity to be a separate facility, the Regional Director improperly disregarded the Health Care Rule's application to the facts of this case and directed an election in a non-conforming unit at LEHHC. The Rule, consciously and unequivocally, incorporates the Medicare Act's definition of what constitutes a single "Hospital." Equally clear and unequivocal, and as fully explicated below, is the fact that under the Medicare Act, LEHHC is the "Hospital", not Unity. The Board's own Rule is clear and explicit that, absent "extraordinary circumstances", the scope of a requested RN unit must be coextensive of the "Hospital" as defined in the Medicare Act. Absent "extraordinary circumstances", which the RD does not find, he simply has no discretion or authority to either contravene or depart from the Board's Rule, or to construe the term single "Hospital" in any way differently from HHS or its constituent entities that, alone, have the statutory authority to administer the Medicare Act. Thus, the unit found by the RD is in clear contravention of the Board's acute care Rule. This is clearly reversible error on his part.

The Health Care Rule which was approved by the Supreme Court in *American Hospital Ass'n v. NLRB*, 499 U.S. 606 (1991), provides that, except in "extraordinary circumstances" or where there are existing nonconforming units, the following units are appropriate in an acute care hospital: (1) all registered nurses; (2) all physicians; (3) all professionals except for registered nurses and physicians; (4) all technical employees; (5) all skilled maintenance employees; (6) all

business office clerical employees; (7) all guards; and (8) all nonprofessional employees except for technical employees, skilled maintenance employees, business office clerical employees, and guards. 29 C.F.R. § 103.30(a)(1)-(8), (b).

The purpose of the Health Care Rule is to prevent fragmentation and proliferation of bargaining units in the acute care hospital context. *See Am. Hosp. Ass'*n, 499 U.S. at 615-17. "An excessive number of bargaining units increases the prospect of jurisdictional disputes and work stoppages, potentially impairing the provision of health care services to the public." *Rush Univ. Med. Ctr. v. NLRB*, 425 U.S. App. D.C. 234, 236, 833 F.3d 202, 204 (2016) (*citing* Collective-Bargaining Units in the Health Care Industry, 53 Fed. Reg. 33900-01, 33906 (Sept. 1, 1988); *Am. Hosp. Ass'n*, 499 U.S. at 615).

In adopting the Rule, it is clear that the Board contemplated that its application to acute-care-hospital employers would be mandatory, so long as the employer meets the definition of the term "acute care hospital" in the Rule: "This portion of the rule ***shall*** be applicable to acute care hospitals, as defined in paragraph (f) of this section." 29 C.F.R. § 103.30(a) (emphasis added); *see also* NLRB Gen. Counsel Memo. 91-3 (May 9, 1991) (same). Significantly, nowhere in the Rule does the Board limit its application to acute care hospitals in a single building. *See* 29 C.F.R. § 103.30(a)(1)-(8), (b). In the Rule's Legislative History, the Board made clear that it applies to all acute care hospitals, regardless of size, or number of beds. *See* 53 Fed. Reg. 33801, 33927.

Section 103.20(f)(2) of the Rule defines an "acute care hospital" as follows:

> (2) *Acute care hospital* is defined as: either a short term care hospital in which the average length of patient stay is less than thirty days, or a short term care hospital in which over 50% of all patients are admitted to units where the average length of patient stay is less than thirty days. Average length of stay shall be determined by reference to the most recent twelve month period preceding receipt of a representation petition for which data is readily available. The term "acute care hospital" shall include those hospitals operating as acute care facilities even if those hospitals provide such services as, for example, long term care, outpatient care, psychiatric care, or rehabilitative care, but shall exclude facilities that are primarily

> nursing homes, primarily psychiatric hospitals, or primarily rehabilitation hospitals. Where, after issuance of a subpoena, an employer does not produce records sufficient for the Board to determine the facts, the Board may presume the employer is an acute care hospital.

The Rule adopts the Medicare Act's definition of the term "Hospital." 29 C.F.R. § 103.30(f)(1). Under the Medicare Act's definition, hospitals are "institutions which are primarily engaged in diagnostic, therapeutic, and rehabilitation services to injured, disabled, or sick inpatients; provide 24-hour nursing service rendered by or under the supervision of a registered nurse; have utilization review and discharge planning procedures; and are licensed as a hospital by a state or local government." *Child's Hospital*, 310 NLRB 560, 561 (1993).

Thus, whether a particular employer constitutes an acute care hospital under the Rule turns on (1) whether patients admitted to the entity do not exceed the minimum stay requirements, and (2) whether it is a "Hospital" as defined by the Medicare Act. If an entity meets those two definitions, the Board "shall" apply the Rule and find that only the eight enumerated acute care bargaining units are allowed, unless "extraordinary circumstances" are present. 29 C.F.R. § 103.30(a).

"To satisfy the requirement of 'extraordinary circumstances,' a party would have to bear the 'heavy burden' to demonstrate that 'its arguments are substantially different from those which have been carefully considered at the rulemaking proceeding,' as, for instance, by showing the existence of such unusual and unforeseen deviations from the range of circumstances revealed at the hearings and known to the Board from more than 13 years of adjudicating cases in this field, that it would be unjust or an abuse of discretion for the Board to apply the rules to the facility involved." 53 Fed. Reg. at 33933 (September 1, 1988). The Board further stated that it would not consider, as extraordinary circumstances, arguments concerning variations between acute care hospitals that were raised and resolved in the rulemaking proceedings, including such matters as

facility size and staffing patterns, increased functional integration, degree of work contacts, cross training, and changes in traditional employee groupings. *See id.* at 33932.

Here, the Regional Director erred by failing to find that LEHHC is an acute care hospital within the meaning of the Rule and directing an election for a subset of behavioral health registered nurses at LEHHC. The evidence presented at hearing plainly demonstrates that LEHHC, not Unity, meets the Rule's definition of an acute care hospital. First, in 2015 and the first quarter of 2016, patients were admitted to patient care units at Emanuel and Randall with an average length of stay of far less than 30 days (an average of 5.9 days). Once established in 2017, Unity also maintained similar patient stay statistics. Between April 2018 and March 2018, patients at Unity were admitted with an average length of stay of far less than 30 days (between a monthly average of 7.4 days and 14.90 days).

Moreover, LEHHC – not Unity – is the "Hospital" as defined by the Medicare Act and the Rule. LEHHC is engaged in providing, by and/or under the supervision of physicians, services for medical diagnosis, treatment, and care of injured, disabled, or sick persons. Without reciting all of the facts again here, that LEHHC is the single, acute care "Hospital" under the Rule and Medical Care Act is corroborated by the overwhelming evidence that LEHHC presented at the hearing. A few points bear emphasis.

First, Unity's Psychiatric Emergency Services Department is part of Emanuel's Emergency Department. All of Emanuel's behavioral health units are now located at Unity.

Second, CMS – the federal agency within the U.S. Department of Health and Human Services in charge of interpreting and administering the Medicare Act – defines LEHHC as a single hospital under the Medicare Act. As such, in May 2018, when CMS found that Unity was not in compliance with certain of CMS's Regulations, Unity's deficiencies put the entire hospital,

including Emanuel and Randall, at risk of losing its status under the Medicare Act and its authorizing Regulations.

Third, the Joint Commission accredits LEHHC, which it deems to include all Emanuel, Randall, and Unity as departments of LEHHC.

Fourth, LEHHC maintains a centralized and entity-wide "Hospital Nurse Staffing Committee" which includes nurses from Emanuel, Randall and Unity, as required by Oregon law. LEHHC maintains one set of Medical Staff Bylaws that govern the medical staff of Emanuel, Randall, and Unity.

Therefore, by definition under the Board's Rule, LEHHC is an acute care hospital; and by definition under the Board's Rule, a separate unit of registered nurses at Unity cannot be deemed an appropriate unit, unless there are extraordinary circumstances that warrant exempting LEHHC from the Rule. The Union did not present any, let alone sufficient, evidence of such circumstances and the Regional Director did not so find. Thus, The Regional Director violated the Health Care Rule by directing an election among only the LEHHC registered nurses who work at Unity.

B. The Regional Director's Decision Contains Virtually No Explanation For Failing To Properly Apply The Board's Health Care Rule To The Undisputed Facts Of This Case

As noted above, the Regional Director erred in failing to apply the Health Care Rule and wrongly determined that Unity is a separate facility. In contrast to the evidence of integration as set forth above and in the foregoing Statement of Facts, the Regional Director fails to cite to any credible evidence established at the hearing or to any Board law to support his finding that Unity is a separate facility. (Decision at 7, 10). Instead, the Regional Director merely assumes that Unity constitutes a single-facility, an erroneous finding upon which his entire opinion is built. (Decision at 7). This assumption turns the Board's Health Care Rule entirely on its head, examining whether LEHHC sufficiently rebutted the presumption that Unity is a single facility. The Regional

Director's superficial analysis of the Health Care Rule is faulty and should be rejected for several reasons.

First, the Decision completely ignores that LEHHC – inclusive of Unity, Emanuel, and Randall – meets the definition of an acute care hospital under the Health Care Rule, which requires that all registered nurses at LEHHC, not just Unity, be in the appropriate unit. Not only does he ignore the record evidence that supports this conclusion, but also he ignores the fact that the Centers for Medicare and Medicaid Services has already designated LEHHC as a single, acute care hospital under the Medicare Act. It is not an accident that in its rulemaking, the NLRB focused on definitions contained in the Medicare Act. The Department of Health and Human Services, through CMS, decides which facilities are hospitals, and which facilities are standalone psychiatric hospitals. By using the definitions contained in the Medicare Act, the Board simply follows the designation assigned by CMS and avoids having to repeatedly litigate the definitions. Rather than apply the Health Care Rule or heed to the CMS's finding, the Regional Director seemingly rejects them with no analysis or citations to supporting decisional law explaining why. He merely dispenses with the Rule in a single, conclusory sentence: "I do not find a basis in the cases cited by the Employer, or Board law more generally, for analyzing the case in the manner the Employer suggests." (Decision at 6.) Such an analysis is deficient as it barely pays lip service to the Board's Health Care Rule.

Second, none of the cases on which the Regional Director relies address the application of the Health Care Rule to an acute care hospital such as LEHHC, the question of whether the application of the single site presumption is consistent with the Rule in this case, or whether in the context of this case there were justifiable bases for dispensing with the Rule in favor of the single-facility presumption. The cases on which the Regional Director relies – *West Jersey Health System*, 293 NLRB 749, 751 (1989), *Stormont-Vail Healthcare, Inc.*, 340 NLRB 1205 (2003), and

St. Luke's Health System, Inc., 340 NLRB 1171, 1172 (2003) – do not stand for the proposition that he cites them for, namely that because LEHHC has three buildings, the Health Care Rule does not apply.

In *West Jersey Health System*, a decision which pre-dates the existence of the Rule, the employer sought a unit of four separate hospitals, which was the employer's entire hospital system. In *Stormont-Vail Healthcare, Inc.*, the employer sought a multi-facility unit of all of its registered nurses in its acute care hospital complex, off-campus psychiatric facility, outlying clinics, and community nursing centers. Thus, the unit urged by the employer therein would have included RNs from both an acute care hospital and various non-acute care facilities, thus mooting the applicability of the Rule. In contrast here, the employer would expressly exclude RN's at its non-acute care satellites and confines the unit to the acute care "Hospital." In *St. Luke's Health System, Inc.*, the employer operated 21 clinics that provided non-acute health care-related services in family practice, rehabilitation, and other specialty areas. The Rule did not apply because of the non-acute nature of the employer's business. In contrast, here, the Employer seeks only a unit of nurses in LEHHC's single, acute care hospital.[9] The cases that the Regional Director relies on to ignore the Rule are simply inapposite to that proposition as they either pre-date the Rule, involve multiple hospitals, or involve a combination of acute and non-acute care facilities.[10]

Third, the evidence supporting that LEHHC is a single acute care hospital under the Rule is not only overwhelming; it is uncontroverted. The Regional Director, however, seemingly ignores this evidence, without explanation.

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[9] As noted above, LEHHC operates some ambulatory clinics in addition to the acute care hospital at issue here. However, the Employer is not seeking to include nurses working in those clinics in the acute care unit. Rather, the entire hearing focused on the nurses working in the LEHHC acute care hospital that includes Emanuel, Randall and Unity.

[10] The RD notes that the Employer cited these cases in its post-hearing brief. But LEHHC relied on them to support its alternative argument that even if Unity is deemed a separate facility, which it is not, applying the multi-facility unit factors also compelled a conclusion that only an LEHHC-wide unit of nurses is appropriate.

Fourth, the Regional Director's refusal to apply the Health Care Rule in the context of this case severely prejudices LEHHC's rights in many respects. All of Emanuel's behavioral health units are now located at Unity. Thus, if a labor dispute occurred at Unity, it would impact how Emanuel and Randall transfer patients to Unity for psychiatric treatment. Emanuel may need to send its behavioral health patients outside of LEHHC to another Portland-area hospital because Emanuel no longer has behavioral health units within its building. Similarly, because Unity's PES is part of Emanuel's Emergency Department, in the event of a labor dispute at Unity, LEHHC's ability to treat psychiatric emergency patients would be impacted.

The Regional Director's refusal to apply the Rule also impairs LEHHC's labor relations functions. Should the Regional Director's Decision be left standing, LEHHC will be faced with negotiating two collective bargaining agreements on a LEHHC-wide basis (for SEIU and UFCW bargaining units), and one on a unit-basis (for ONA at Unity). LEHHC will be required to bargain with a fragmented unit of registered nurses in one building of its hospital.

The Decision also prejudices LEHHC because it arguably opens the door to other micro- or sub-units at LEHHC, merely on the basis that the employees in the proposed unit are housed in a separate building from their counterparts. Allowing a registered nurse unit solely at Unity threatens the uniform operations and care that LEHHC has established for Emanuel/Randall/Unity. There is no reason to upset this, especially when the Board Health Care Rule exists to avoid the creation of such fragmented units in the acute care context in the first place.

In sum, it is clear that in making this separate-facility finding, the Regional Director ignored the record evidence and Board law, and created an artificial distinction between nurses at Emanuel and Randall versus the nurses at Unity. The Regional Director's erroneous and barely-explained finding was used to find that the Health Care Rule did not apply to LEHHC, and then

used as the basis for his presumption that Unity constituted an appropriate single facility. Based on this clear error of law and fact, the Board should reverse the Decision.

C. The Regional Director Ignored The Congressional And Board Policy Against Proliferation Of Bargaining Units In The Health Care Industry And Established Board Precedent Applicable To Acute Care Hospitals

As noted above, the National Labor Relations Act expresses a Congressional policy against the proliferation of bargaining units in the health care industry. As the Supreme Court has recognized, Congress admonished that "'[d]ue consideration should be given by the Board to preventing proliferation of bargaining units in the health care industry.'" *Am. Hosp. Ass'n*, 499 U.S. at 615-16 (quoting the House and Senate Committee Reports on the NLRA Amendments of 1974, S. Rep. No. 93-766, at 5, H.R. Rep. No. 93-1051, at 6-7 (1974)) (citations omitted). The unique nature of a hospital setting requires the Board "to avoid disruption of patient care and disturbance of patients." *NLRB v. Baptist Hosp. Inc.*, 442 U.S. 773, 778 (1979).

Here, the Regional Director failed to even discuss or consider the impact of his Decision on proliferation/fragmentation concerns, although LEHHC raised these issues in the proceeding below. (Employer's Post-Hearing Brief, at 15.) Under the Regional Director's analysis, other nurse units at Emanuel or Randall can now, because of their "specialties" try to proceed to an election in their own unique unit. This cannot be squared with the Health Care Rule or broader decisional law in representation proceedings. The only distinguishing feature separating units of nurses at Randall and Emanuel from the Regional Director's separate nursing unit at Unity is a one-mile difference of proximity – a slender reed in the acute care context in 2019. This outcome is directly contrary to the Board's Health Care Rule, the reasons for adopting it in the first place, and the existing bargaining units already well-cemented at LEHHC.[11]

[11] Given that the Regional Director ignored both the Health Care Rule, and the overwhelming evidence that Unity cannot be a separate unit, the only logical inference is that the Regional Director's appropriate unit finding is based on "extent of organization," which is expressly prohibited by the Act. *NLRB v. Metropolitan Life Insurance*

D. Even If The Health Care Rule Does Not Apply, The Regional Director Erred In Applying The Multi-Facility Factors And Concluding That LEHHC Did Not Overcome The Single-Facility Presumption

Before the Regional Director, LEHHC alternatively argued that even if the Regional Director found that the Health Care Rule did not apply, the Board's multi-facility unit factors similarly compel a conclusion that the only appropriate unit here is one of all registered nurses in the LEHHC acute care hospital. In determining whether a multi-facility unit is appropriate, the Board evaluates the following factors: employees' skills and duties; terms and conditions of employment; employee interchange; functional integration; geographic proximity; centralized control of management and supervision; and bargaining history. *Alamo Rent-A-Car*, 330 NLRB 897 (2000).

In evaluating these factors, the Regional Director concluded that LEHHC failed to rebut the presumption that a unit of registered nurses at Unity is appropriate. This conclusion is based on a faulty analysis, ignores critical facts, and relies on a results-oriented and skewed application of multi-facility factors to direct an election in the Union's cherry-picked unit.

1. "Common Control" Over Terms and Conditions of Employment and Functional Integration

First, the Regional Director's analysis of the "common control" factor is faulty. The Regional Director seeks to minimize the substantial control by LEHHC over Unity through his "layers of control" conceit, essentially dismissing it because more substantial control supposedly exists at a level that is not co-extensive with the alternative unit scope LEHHC proposed. This is not so, and the Regional Director ignores many facts which find that there is significant control at the LEHHC level. All nursing leadership reports within the LEHHC hospital hierarchy. Nichols, Unity's Interim President, reports directly to Houston, the President of Randall and the Interim

Co., 380 U.S. 438, 441-442 (1965); *New England Power Co.*, 120 NLRB 666 (1958); *John Sundwall & Co.*, 149 NLRB 1022 (1964).

President of Emanuel. Howard, the Vice President and Chief Nursing Officer at Unity, reports to Nichols.

There are also LEHHC-only policies and procedures that evidence control by LEHHC over Emanuel, Unity, and Randall. The Regional Director seemingly lumps these policies together as showing control "over Unity by the Legacy Health system," not LEHHC. However, the record clearly shows that LEHHC maintains policies and control over LEHHC, inclusive of Emanuel, Randall, and Unity:

(1) LEHHC maintains one set of Medical Staff Bylaws, "Medical Staff Bylaws of Legacy Emanuel Hospital & Health Center," which together govern the Medical Staff of Emanuel, Randall, and Unity;

(2) LEHHC maintains a centralized and LEHHC-wide "Hospital Nurse Staffing Committee" which sets the staffing plans for all nursing units within LEHHC;

(3) LEHHC shares major operational and support services (floating nurses, housekeeping, maintenance, security, patient access, spiritual care, pharmacies, food and nutrition, therapy, and human resources);

(4) Patient transfers between Unity and Emanuel or Randall are handled in the same way as when the behavioral health units were part of Emanuel, which is different from transfers to other hospitals, including other Legacy hospitals;

(5) Patient billing is all under LEHHC; and

(6) LEHHC already has bargaining units (SEIU and UFCW) that include employees working across the single acute care hospital of Emanuel, Randall and Unity.

The above is significant evidence that LEHHC is both one hospital and that LEHHC exercises significant control over how Unity operates on a daily basis. These are not evidence of system-wide control by Legacy.

The Regional Director also relies on the fact that nurses at Unity are supervised by their immediate supervisors and that there is minimal evidence that decisions at the LEHHC-level impact Unity. (Decision at 2-3.) However, such immediate supervision does not show that Unity

is a separate facility; instead, it merely shows that supervisors trained in the same specialty of the nurses supervise employees within the same department. It is not at all surprising that a nursing manager at Emanuel who specializes in, for example, cardiology, is not supervising a nurse at Unity in his or her provision of behavioral mental health. For purposes of the analysis here, the significance of immediate supervision of Unity's nurses by other Unity nurses is remote. Any department in any acute care hospital has separate supervision for employees, and for many practical reasons, the supervisors need to remain at or close to the unit/department where they supervise employees. Separate supervision based on medical specialty does not transform a department into a separate stand-alone facility. In every acute care hospital around the country, nursing supervision of different departments is based on nursing specialties.

The Regional Director further concludes that LEHHC does not exercise control over Unity because the LEHHC Nurse Staffing Committee "does not appear to have any actual control on staffing levels." (Decision at 8.) Such a conclusion strains credulity and it is inconsistent with the Nurse Staffing Committee's own Charter and Oregon law, which expressly states that one of its key reasons for existing is to ensure that staffing levels at LEHHC are adequate and consistent with Oregon law. (EX 26.) As discussed above, Oregon law requires a hospital-wide nurse staffing committee, and the statute dictates what the staffing plans generated by the nurse staffing committee have to include, that the staffing committee must meet once every three months, and a dispute resolution procedure if management and the nurses cannot agree. (Oregon Revised Statues 441.152-441.192 (2015); Oregon Administrative Rules, Chapter 333, Division 510 (2017)). As summarized in the Statement of Fact, the staffing plans set minimum staffing requirements in each hospital department/unit, among other things. (Oregon Administrative Rules, Chapter 333, Division 510-0110.)

Also as noted above, under Oregon law if the nurses are represented, then the union picks the staffing committee representatives. (Oregon Administrative Rules, Chapter 333, Division 510-0105(4)(c)) If they are not, then there has to be a process for the nurses to select their representatives. (*Id.* at 510-0105(4)(a).) The Regional Director's decision here will result in two different processes for selecting nurses on the same hospital-wide nurse staffing committee.

In a similar vein, the Regional Director also ignores the undisputed fact that LEHHC maintains one set of Medical Staff Bylaws, "Medical Staff Bylaws of Legacy Emanuel Hospital & Health Center," which together govern all of the medical staff at Emanuel, Randall, and Unity. (EX 55, Tr. 588-590.) It bears emphasis that this is an LEHHC-specific set of Medical Bylaws, not one for the entire "Legacy Health System." And, the Bylaws specifically define the "Hospital" as LEHHC, and note that "Mental Health" is one of the established departments at LEHHC. (EX 55, pp. 7, 15.) The record further reflects that Dr. Greg Miller of Unity serves as the Chair of the Mental Health Department within LEHHC. (EX 55, p. 15; Tr. 590 (**Q:** And who occupies that chair position at this point? **A:** Dr. Greg Miller from Unity serves as the chair of mental health [for LEHHC]).)

The Regional Director also seemingly ignores the undisputed fact that Unity's Psychiatric Emergency Services (i.e., the psychiatric emergency room at Unity) or "PES" is a part of Emanuel's Emergency Department. Unity's "Scope of Services for Psychiatric Emergency Services" readily confirms this fact. (UX 10 at pp. 92-93; emphasis added). Similarly, all of Emanuel's behavioral health units are now located at Unity. (Tr. 127, 579-581.) These facts are significant because if a labor dispute occurred at Unity, it would impact how Emanuel and Unity transfer patients to Unity for psychiatric treatment.

2. Employee Skills and Duties

The Regional Director also relies on the alleged skill differences between the nurses at Unity versus those at Emanuel and Randall. (Decision at 4.) Once again, the distinction drawn by the Regional Director is arbitrary. It does not show that Unity is an independent, separate facility from LEHHC. To be sure, nurses at Unity do work with different patients than nurses at Emanuel and Randall, but their fundamental jobs are the same. All LEHHC nurses have similar or the same work hours and wage scales, policies and procedures and fringe benefits are all the same. The fact that patient care at psychiatric medical services department does not require intravenous drips or heart monitoring as often as patients being seen in the trauma center does not transform Unity into a separate facility. (*See* Decision, at 8.) These are differences inherent in the practice of medicine and its various specialties. If the Board considered the differences from nursing specialty to nursing specialty in acute care hospitals, then it certainly would not have developed the Health Care Rule that deemed a unit of "all registered nurses" appropriate for collective bargaining in the first place. The Regional Director's analysis simply cannot be squared with common sense and it fails to appreciate how modern, complex hospitals, which provide a range of diverse health care services in large cities, operate in 2019.

Newton-Wellesley Hospital, 250 NLRB 409 (1980) is instructive. There, the Board found a registered nurse unit to be appropriate in an acute care hospital that included psychiatric units. The Board cited in support of its conclusion the following factors: the registered nurses' possession of a license and their similar education and training; their ability to interchange among the hospital's units; and their unique responsibility for patient care 24 hours a day. *Newton-Wellesley Hospital*, 250 NLRB at 409-412. With respect to the registered nurses in the psychiatric units, the Board rejected the contentions that other professionals should he included in their unit despite its finding that the RNs had frequent and substantial contact with other professionals, but the Board

did not carve out nurses in the psychiatric unit from the bargaining unit because their work was different than other nurses. *Id.* at 410.

Newton-Wellesley Hospital predates the Health Care Rule, and it is significant because it demonstrates that the distinctions drawn by the Regional Director between nurses' work at Unity and nurses' work at the rest of LEHHC are artificial and contrived. Even before the promulgation of the Health Care Rule, the Board has found that registered nurses at a hospital – regardless of their specialty whether it be mental health or cardiology, should be included in one cohesive unit. The foregoing factors cited by the Board in support of its conclusion of the appropriateness of a separate registered unit at Newton-Wellesley all apply to the registered nurses employed at LEHHC. *See also Jersey Shore Medical Center-Fitkin Hospital*, 225 NLRB 1191 (1976) (refusing to allow a separate unit of nursing school instructors apart from other nurses at a single hospital).

Further, the Regional Director's reliance on evidence related to medical specialty to conclude that Unity nurses perform dissimilar work is also factually inaccurate. Indeed, a close comparison of the Standards of Care at Unity with the Standards of Care at Emanuel, reveal that registered nurses in both departments perform the same basic functions, albeit tailored to patients suffering different medical problems, including (1) coordinating "the interdisciplinary plan of care" and applying the nursing process in doing so; (2) completing a nursing assessment within four hours of admission; (3) assess/reassess major bodily functions and document those assessments; and (4) assess and document fall risk on admission. (*Compare* EX. 47 *with* UX 10 at pp. 61-63.) The Union's own witnesses also readily acknowledged that nursing practice varies from specialty to specialty, but that nurses same general nursing responsibilities are applicable across all nursing responsibilities: "Patient assessment, care planning, and then carrying out any treatments orders that we need to" and that as a nurse, all "deal with mental health issues everywhere." (Tr. 343, 344, 432.)

3. Employee Interchange

The Regional Director also ignores the significant evidence of employee interchange involving employees other than nurses, which does show integration within LEHHC, among Emanuel/Randall/Unity. The record evidence discussed in detail above demonstrates that medical and non-medical employees work among the three buildings. The relatively limited employee interchange among nurses is based on nursing specialty, not because Unity is a separate facility. In other words, it is the same among nurses working in different departments in an acute care hospital all contained in a single building. An emergency room nurse would not necessarily have the skill set to transfer to a neonatal intensive care unit, for example.

In addition, for nurses who have the skill set to serve patients in different departments at LEHHC, among Emanuel/Randall/Unity, the record reflects that there is interchange. Over a one-year period, 30 registered nurses interchanged between Randall or Emanuel, and Unity, working between one to 19 shifts. Nurses in the Resource Pool are hired to be available to float to various Legacy hospitals, including LEHHC. Over the last year period, 98 Resource Pool nurses have worked at Unity. While nurses in the Resource Pool work at facilities Legacy-wide, the fact that nurses can in fact float within Emanuel/Randall/Unity shows that Unity is not distinct or a separate facility, insofar as it is just like any other specialty unit in a hospital.

4. Bargaining History

In his analysis, the Regional Director also entirely discounts and seemingly ignores that SEIU and UFCW both represent existing, Board-certified bargaining units at LEHHC because there is no bargaining history for the Union's preferred petitioned-for unit. (Decision at 6.) This distinction is red herring. When examining bargaining history, the Board has never limited its consideration to whether there is a bargaining history for the petitioned-for unit. *See, e.g.*, *Spartan Department Stores*, 140 NLRB 608, 610 (1963) (considering evidence of bargaining unit history

in Dallas and San Antonio in determining that citywide unit in Oklahoma City was appropriate); *see also* NLRB Outline of Law and Procedure in Representation Cases, § 13-900, Bargaining History (June 2017) ("The pattern of bargaining, as any study of bargaining unit principles will readily indicate, plays a significant role in all phases of unit determination, including, of course, the resolution of questions pertaining to single-unit or multilocation unit scope."). There has been successful bargaining in the LEHHC-wide units represented by the SEIU Local 49 and UFCW Local 555. Why disturb it? The Regional Director wrongly discounted this factor in his analysis, when the Board has in fact accorded it significant weight in prior decision. *See, e.g.*, *California Pacific Medical Center*, 357 NLRB 197, 197 (2011).

5. Geographic Proximity

The Regional Director discounted the fact that Unity is located only one mile away from Emanuel and Randall, and that Unity is only located in a separate building because Emanuel lacked the capacity to house the type of psychiatric operation at Unity. (Tr. 53-55, *see also* Tr. 30, 35.) The fact that Unity is housed in a separate building has nothing to do with Unity being a separate facility; instead, it is merely a product of LEHHC identifying and responding to the needs of patients in the Portland area and patient need and establishing an additional building where these patient service are offered to the public. It is no different than a children's hospital, like Randall for instance, being located in separate buildings with a close proximity to one another.

6. Case Discussion

The cases cited by the Regional Director in support of his finding that LEHHC did not overcome the single-facility presumption are all distinguishable. He relies on nine Board decision in his analysis of the single-facility presumption. To begin, eight of the decisions do not involve acute care hospitals at all; the employers there did not even operate in the health care industry. Therefore, those cases have no relevance here in the context of an actual acute care hospital, nor

has the Regional Director shown how they might be relevant, other than citing to them for general descriptions of the multi-unit factors. Nor do the cases that the Regional Director relies on address the proliferation concerns raised by LEHHC and the Board's Health Care Rule.

The only case that the Regional Director cites that involves a hospital is *California Pacific Medical Center (St. Luke's Hospital Campus)*, 357 NLRB 197, 197-198 (2011) and it both distinguishable in many respects, and also supportive of the Employer's position in others. There, a union sought to represent a unit of technical, service, and clerical at one of the employer's four, separate hospitals – St. Luke's. *California Pacific Medical Center*, 357 NLRB at 197. The employer argued that the St. Luke employees needed to be included in a unit with the employer's other three hospitals. The employer, unlike LEHHC, operated four separate hospitals, including St. Luke's, which had merged with the employer's three other campuses prior the representation proceeding. This is not analogous to the facts of this case. Unlike the four hospitals in *California Pacific Medical Center*, Unity is not a separate facility or hospital, and it did not merge with LEHHC. Since its inception, Unity has at all times operated as a unit/department LEHHC.

In addition, in deciding that the multi-unit facility was not appropriate, *California Pacific Medical Center* placed considerable emphasis on the extensive bargaining history at St. Luke's: "[t]here is a lengthy, separate history of bargaining in the St. Luke's unit. Indeed, for 70 to 80 years, including through 2009 when the instant. petition was filed, St. Luke's was separately represented." *Id.* The Board reasoned that "[t]his extensive bargaining history strongly supports a finding that the single facility unit at St. Luke's is appropriate." *Id.* In contrast, here, there is no extensive bargaining history at Unity. Indeed, the only bargaining unit history here is of LEHHC-wide units.

In sum, even if Unity is considered to be a separate facility (which it is not), LEHHC overcame the singe facility presumption. As set forth in detail in the Statement of Facts, LEHHC,

inclusive of the Emanuel, Randall, and Unity units, all operate and bill patients as one hospital. They are functionally integrated both as to the services provided and as to the employees who provide them. All three are accredited, evaluated, and surveyed as one hospital by CMS, the Joint Commission and the OHA. All of the administrative operations and human resource functions at LEHHC are centralized in that they all use uniform job applications, job descriptions, and applicant screening, hiring practices. All nurses at LEHHC must be licensed registered nurses, who have graduated from an accredited nursing school and are required to pass a uniform state-licensing exam. The Regional Director erred in concluding that LEHHC did not rebut the single facility presumption.

VI. CONCLUSION

For all of the reasons set forth above, LEHHC respectfully requests that the Board grant its Request for Review and direct the Regional Director to apply the clear terms of the Board's Health Care Rule for unit determination in this case.

Dated: July 11, 2019

Respectfully submitted,

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CERTIFICATE OF FILING AND SERVICE

The undersigned hereby certifies that on July 11, 2019, the foregoing **EMPLOYER'S REQUEST FOR REVIEW OF THE REGIONAL DIRECTOR'S DECISION AND DIRECTION OF ELECTION** was e-filed with the Office of Executive Secretary of the National Labor Relations Board.

The undersigned further certifies that on July 11, 2019, the foregoing **EMPLOYER'S REQUEST FOR REVIEW OF THE REGIONAL DIRECTOR'S DECISION AND DIRECTION OF ELECTION** was served on the following parties as indicated below:

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